**Jennifer D. Nichols, MA, LPC-S**

Jennifer Nichols Counseling ~ 11711 Cypress N. Houston, Cypress, TX 77429

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**CONFIDENTIAL INFORMATION SHEET**

Please fill out as completely as you can. Please **PRINT** Neatly. All information will be held in strict confidence.

Date: / /\_\_\_\_

**PATIENT INFORMATION:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_ /\_\_\_ /\_\_\_\_ Age: \_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_

Home Phone: (\_\_\_\_ )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: (\_\_\_\_\_ )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell: (\_\_\_\_ )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: M  F Marital Status:  M  S  W  D

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for visit:  Individual  Couple  Family

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient:  Self  Spouse  Other (please indicate): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_

Home Phone: (\_\_\_\_ )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: (\_\_\_\_ )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell: (\_\_\_\_\_ )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Legal Guardian if patient is a minor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **(Signature gives consent to treat)**

**1. I, the undersigned, accept financial responsibility for payment of all fees at the time of visit.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Client’s (or responsible party) Signature Date

**Policies and Procedures**

**Fee Structure: The patient is financially responsible for payment of fees, which will be**

**collected at the time of service.** You will be charged your full session fee for cancelled appointments unless notice is received at least \***24 hours** prior to the appointment time so that the time may be scheduled for another patient. **Except in emergencies, cancellations must be made at least 24 hours in advance to avoid being charged.**

**Confidentiality:** Information shared in session is held in strictest confidence according to federal law (Regulation 42 CFT Part 2). Exceptions include: legal obligations (such as child abuse, elder abuse, testimony required by a judge, personal danger to self or an identifiable victim); information provided to parents if the patient is a minor; and consultation with supervising professionals. Advice may be elicited from professional peers in regard to your case, without revealing identity. Release of information to another professional may be done only with your written consent.

**Patient Privacy:** Laws have been enacted for patient privacy. It is important to know that emails and cell phone conversations are not secure or guaranteed of privacy because they can potentially be intercepted. Therefore, by signing this document you understand that if we have correspondence by email or cell phone, there is a potential for confidentiality to be compromised.

**Length of Sessions:** Sessions are scheduled for approximately 45-50 minutes for individuals and 90 minutes for couples/familes. Intake sessions are $200 for individuals and $260 for Family/Couple Therapy. Regular sessions for individuals or parent consults are $150. Regular sessions for Family/Couple Therapy are $260.

I understand and accept the policies concerning both the cancellations of appointments and payment for services. I will be responsible for the agreed upon payment due of $ or $\_\_\_\_\_\_\_\_\_ (\_\_\_\_\_\_) per session.

 Initials

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Client’s (or responsible party) Signature Date

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

• Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly with appropriate authorization to share information.

• Obtain payment from third-party payers, if applicable.

• Conduct normal healthcare operations such as quality assessments and record keeping.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: \_\_\_\_\_\_\_\_\_\_\_\_ Initials: \_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pre-Authorized Charge Form**

I authorize **Jennifer D. Nichols, MA, LPC-S** to keep my signature on file and to charge my

Credit Card listed below for:

 (Initial the Box) You will be charged your FULL SESSION FEE for failing to notify me of your intention to miss your appointment BEFORE the 24 hour window preceding your appointment time (or not showing up for your appointment).

You will be responsible for the above agreed amount when appointments are missed or not cancelled BEFORE the 24 hour preceding window of the original appointment time. Your therapeutic relationship can and may be terminated following 3 missed appointments.

I understand that this form is valid for one year unless I cancel the authorization through written notice to the service provider.

Client’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardholder’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card Type:

 Visa  MasterCard  Discover  American Express  HAS/FLEX

Account Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Card Verification Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Zip Code associated with Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardholder’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_